PRENATAL QUESTIONNAIRE FOR ASSIGNMENT OF PREGNANCY RISK

Patient Name: ____ Date of Birth: _________________

Will you be over 35 years of age when the baby is due? NO ____ YES ____

Will the father be over 55 years of age when the baby is due? NO ____ YES ____

Are you or the baby's father:

1) Eastern European Jewish Ancestry? NO ____ YES ____

   Do you desire Tay Sachs screening? NO ____ YES ____

   Do you desire Canavan screening? NO ____ YES ____

2) African American Ancestry? NO ____ YES ____

   Do you desire Sickle Cell screening? NO ____ YES ____

3) European Ancestry? NO ____ YES ____

   Do you desire Cystic Fibrosis screening? NO ____ YES ____

4) Mediterranean (Italian, Greek) or Southeast Asian Ancestry? NO ____ YES ____

   Do you desire Inherited Anemias screening? NO ____ YES ____

Have you, the baby's father or anyone in either family had:

- Inherited Anemia, i.e. Thalassemia (Italian, Greek, Asian)? NO ____ YES ____
- Neural tube defect (Spina Bifida, Anencephaly)? NO ____ YES ____
- Congenital heart defect? NO ____ YES ____
- Down's syndrome? NO ____ YES ____
- Tay Sachs (Jewish, Cajun, French Canadian)? NO ____ YES ____
- Canavan? NO ____ YES ____
- Sickle Cell Disease or Trait (African)? NO ____ YES ____
- Hemophilia or other blood disorders? NO ____ YES ____

- Muscular Dystrophy? NO ____ YES ____
- Cystic Fibrosis? NO ____ YES ____
- Huntington's chorea? NO ____ YES ____
- Mental Retardation/Autism? NO ____ YES ____
    - If yes, was person tested for Fragile X? NO ____ YES ____
- Maternal Metabolic Disorder (Diabetes, PKU)? NO ____ YES ____
- Other inherited genetic or chromosomal disorder? NO ____ YES ____
- Other birth defects not listed above? NO ____ YES ____

Have you or the spouse of this baby's father in a previous marriage had three or more spontaneous pregnancy losses? NO ____ YES ____

Were any fertility drugs used to help cause this pregnancy? NO ____ YES ____

Have you had a previous difficult of traumatic vaginal delivery or shoulder dystocia? NO ____ YES ____

Have you ever had a previous Cesarean birth? NO ____ YES ____

Have you had a problem with blood type incompatibility with previous pregnancies? NO ____ YES ____

Have you ever been treated for venereal disease or had a positive test for syphilis? NO ____ YES ____

Do you smoke more than one pack of cigarettes per day? NO ____ YES ____

Do you use other tobacco products? NO ____ YES ____

Do you take more than occasional social alcoholic drinks? NO ____ YES ____

Do you routinely use illicit/recreational drugs? NO ____ YES ____

Have you or the baby's father been exposed to dangerous drugs, chemicals, irradiation or infectious agents? NO ____ YES ____

Have you had any suspected exposure to AIDS? NO ____ YES ____

Are you a vegetarian or do you have any known or suspected nutritional deficiency? NO ____ YES ____

Do you have severe varicose veins or have you ever had phlebitis? NO ____ YES ____

Have you or any family members ever had a blood clot?	NO ____	YES ____
Have you ever had a prior stillborn infant?	NO ____	YES ____
Have you ever had a baby that weighed more than nine pounds?	NO ____	YES ____
Do you weigh over 200 pounds?	NO ____	YES ____
Have you ever had blood in your urine?	NO ____	YES ____
Do you have trouble with recurrent urinary tract infections or kidney ailments?	NO ____	YES ____
Have you ever had a prior premature or immature delivery? Have you been told you have an incompetent cervix?	NO ____	YES ____
Do you have any cardiac problem such as rheumatic heart disease, congestive heart failure or mitral valve prolapse?	NO ____	YES ____
Have you ever been advised to have a prophylactic antibiotic during dental work, D&C or childbirth?	NO ____	YES ____
Do you have frequent exposure to blood in medical or dental settings? Work in a renal dialysis unit?	NO ____	YES ____
Have you ever been rejected as a blood donor?	NO ____	YES ____
Do you have acute or chronic liver disease, or live in a household with persons infected with Hepatitis B Virus?	NO ____	YES ____
Do you have a medical illness that requires blood transfusions?	NO ____	YES ____
Are you of Asian, Pacific Island, or Native Alaskan decent or were you born in Haiti or Sub-Saharan Africa?	NO ____	YES ____
Have you ever had a genital lesion you thought might be herpes?	NO ____	YES ____
Do you own or care for a cat?	NO ____	YES ____
Have you ever been told you have a bleeding tendency, low platelets (idiopathic thrombocytopenia purpura) or any other trouble with your clotting system?	NO ____	YES ____
Have you ever had a severe intestinal illness such as ulcerative colitis or Crohn's disease?	NO ____	YES ____
Have you ever been the victim of domestic violence?	NO ____	YES ____
Have you ever been the victim of sexual abuse?	NO ____	YES ____

Do you have a history of depression? NO ____ YES ____

Do you have a history of postpartum depression? NO ____ YES ____

Have you ever had a sensitivity to latex? NO ____ YES ____

Are you a Jehovah's Witness? Would you refuse blood or blood products to preserve your life or health, or that of your baby? NO ____ YES ____

Thank you for taking the time to complete the pregnancy profile.

Having answered all of the questions in the negative will not guarantee you a perfect pregnancy; it will at least put you into a low risk group, with a high probability of a good outcome for which routine testing procedures should be adequate.

It is important for you, the doctors and your unborn child that all questions are understood and that any answered "yes" are fully discussed and your added obstetrical risk evaluated. After you thoroughly understand your position and options, we would appreciate your signing the form below.

I have discussed with Simmonds, Martin & Helmbrecht the above questions which are answered "yes" and understand that:

A. ______No extraordinary pregnancy risk is assigned.

B. ______I am at additional risk for the following:

I desire further testing and/or counseling for:

I am referred for amniocentesis and genetic counseling:

Signed ____
Patient Signature Date

Signed ____
Physician Signature Date

TO ALL OB PATIENTS –

If at any time during your pregnancy you have an insurance change, our office must be notified immediately. Even if your insurance changes the day of your delivery, please have someone contact our billing office at 301-414-2305.

We must obtain an authorization number from your insurance company before you deliver in order to get paid. If we are not notified of your insurance change, you will be held financially responsible for your account.

In order for our office to obtain authorization from your insurance we must have a copy of your new insurance card in our file.

Thank you in advance for your cooperation and understanding of this important matter.

Sincerely,

Simmonds, Martin & Helmbrecht

CURRENT INSURANCE INFORMATION

COMPANY NAME: ____

GROUP NUMBER: ________________________________ID #: _________________________

POLICY HOLDER NAME: _______________________________ DOB: ___________________

____
Patient Signature Date

SIMMONDS, MARTIN & HELMBRECHT
WE LISTEN, WE TEACH, WE CARE
AN ADVANTIA HEALTH PRACTICE

INFORMED CONSENT FOR HIV TESTING

With my signature below, I acknowledge that I have read (or have had read to me) and understand the following information:

FACTS ABOUT HIV TESTING: (HIV – 1 antibody or other HIV tests)

1. My blood will be tested for signs of infection by the human immunodeficiency virus, the virus that causes AIDS
2. My consent to have my blood tested for HIV should be FREELY given
3. I understand that every attempt will be made to keep the results of this test confidential, but that confidentiality cannot be guaranteed

WHAT A POSITIVE TEST RESULT MEANS:

A. A positive HIV test means that I have the HIV infection and can spread the virus to others by having sex or sharing needles
B. A positive HIV test DOES NOT mean I have AIDS – other tests are needed
C. If my test result is positive, I may experience emotional discomfort and if my test result becomes known in the community, I may experience discrimination in work, personal relationships and insurance

WHAT WILL BE DONE FOR ME IF MY TEST IS POSITIVE:

A. I will be told what needs to be done to keep me in good health and will be given a copy of the Department of Health and Mental Hygiene's publication, "Directory of Counseling and Referral Resources for HIV Seropositive Persons." Which contains information about the medical, social, psychological, or legal services that will be helpful to me
B. I will be told to keep from spreading my HIV infection by:
    a. Avoiding sexual intercourse or practice SAFE sex
    b. Not sharing drug needles – better still, getting off drugs
    c. Not donating or selling my blood, plasma, organs or sperm
    d. Avoiding pregnancy or if I'm male not causing a woman to get pregnant
    e. Not breastfeeding or donating breast milk
C. If I have signs or symptoms of HIV infection, my name will be reported to the local health department to assist me in obtaining services and to help the health department understand and control the AIDS problem
D. I know that my local health department or doctor may assist me in notifying and referring my partner(s) for medical services, without giving my information to my partner(s)
E. If I refuse to notify my partner(s), my doctor may either notify them or have the local health department do so. In this case, my name will not be used.
F. Maryland law requires that when a local health department knows of my partner(s), it must refer them for care, support and treatment.

I have had the chance to have my questions about this test answered.

AGREE to have blood drawn [ ]   **DECLINE** to have blood drawn [ ]

I have already had my blood drawn & will have my records transferred [ ]

____

Print Name   Signature   Date

____

Signature of Counselor   Date